

Colorado EMS Provider Information Change/Replacement Certificate Request

(All requests must include your original ink signature)



Colorado Department
of Public Health
and Environment

Date of Request: ____/____/____

Full Name: _____
(LAST FIRST MIDDLE -- as it appears on your current certificate)

Current Address: _____

Current City, State, and Zip Code: _____

Current Phone: _____ Check one: ☐ Home ☐ Work ☐ Mobile

Colorado EMS Provider Certification #: _____ Social Security #: _____
(For identification purposes only. SSN will not be released)

Colorado EMS Provider Certification Level: ☐ EMT (formerly EMT-Basic) ☐ EMT-Intermediate
☐ Advanced EMT ☐ Paramedic

Please check the following type of change or request:

- ☐ Address change (as entered above)
☐ Phone number change (as entered above)
☐ Name Change (copies of legal court documents supporting your name change request must accompany this document. Examples of legal documents accepted include: marriage licenses, divorce decrees, other legal recognition of name change by the court system)

Please change my name to the following: _____

Replacement Certificate Request: (please indicate below why you are requesting a replacement certificate)

- ☐ The Department issued certificate has not been received for at least three (3) months following my application submission and processing
☐ Previous certificate was destroyed
☐ Previous certificate was lost
☐ Legal name change (include copies of legal court documents as described above)
☐ Other: _____

Downgrade of EMS Provider level other than through the renewal process.

- ☐ Please downgrade my EMS Provider level to the following level: _____

Please allow 30 calendar days for the processing of a replacement certificate request - Persons whose certification is due to expire within three months of a request will not be processed, and are encouraged to begin the renewal process.

Original ink signature is required

Date of signature

State statute 25-3.5-203 and Board of Health rules 6-CCR-1015-3, Chapter 1, authorizes the Department to ask for pertinent personal information for the purposes of EMS Provider certification. The Department uses this information for verification purposes only. Personal information, including address, phone number, social security number, gender, age, and fingerprints, will not be released unless authorized or required by law.

MAIL COMPLETED FORM TO:
Colorado Department of Public Health and Environment
EMS Provider Certification
HFEMSD-EMTSS-A2
4300 Cherry Creek Drive South
Denver, CO 80246-1530

For Office Use Only:

Date entered: ____/____/____

By: _____
(initials)